

**MULTI-PAYER ADVANCED PRIMARY CARE PRACTICE DEMONSTRATION
EVALUATION**

INTERVIEW PROTOCOL

Office of Aging Staff and Other Patient Advocates

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[Note to state teams: We will interview individuals who advocate on behalf of the aged in all states, and individuals who advocate on behalf of special populations in states that are specifically targeting such populations with some kind of intervention. Special populations can include: Medicare and Medicaid dual eligibles; children; racial and ethnic subgroups; people living in rural or inner-city areas; and persons with chronic illnesses, mental illnesses, and disabilities.]

Introduction

Thank you for making time to speak with us today. As we mentioned in our email to [name of our contact in their organization], we are researchers from RTI, the Urban Institute, and the National Academy of State Health Policy (NASHP), evaluating the Multi-Payer Advanced Primary Care Practice (MAPCP) Demonstration. We'd like to focus on learning about the period after Medicare joined the state's initiative and your thoughts on the future. Since we're asking about a number of different periods of time, we have created a visual timeline and logic model to differentiate each time period *[show the respondent the state's timeline and logic model]*.

We are particularly interested in the impact of the initiative on Medicare and Medicaid beneficiaries generally and special populations (such as those dually eligible for Medicare and Medicaid) specifically. We understand that some changes are system wide and may not affect these groups differently, but other changes that payers or practices make may be tailored to these groups to some degree and have different impacts on these patient populations.

We'd like your candid views about this initiative. We want to assure you that we will not quote you by name without getting back in touch with you to get your permission first. We would like to record our conversation, to ensure our notes from today are complete. Is this OK with you? Do you have any questions before we start the interview?

Background

1. *[Before Visit]* Could you tell us a little about [name of organization] and what your role is?
 - a. *[Before Visit]* How long have you worked at [name of organization]?
2. Thinking about care received by patients who [are/have] [state the special populations the interviewee represents], what are some problems with how care is currently delivered to this population in [name of state]?
 - a. To what extent do you see problems with:
 - i. Patients and families or caregivers having access to care when they need it? Could you give me an example of that?
 - ii. Effective communication between patients, families or caregivers, and practice staff (including doctors and other staff)? Could you give me an example of that?

1. Does this include communication related to shared decision-making?
 2. Does this include communication related to self-management?
 - iii. How do practices, community health [teams/networks], and plans communicate with patients? Families or caregivers? Patients who do not speak or cannot read English?
 - iv. Quality of care? Could you give me an example of that?
 - v. Care coordination, specifically in instances where patients visit a specialist or are seen in a hospital-setting and require follow-up from their primary care provider?
 - vi. Patients and families or caregivers being able to better able to self-manage their health and medical conditions?
- b. *[Optional]* Do you see any major differences for Medicare beneficiaries, Medicaid beneficiaries, or other special populations?

[State-specific name of PCMH initiative]

3. *[Before Visit]* How are you involved in [name of state]'s [state-specific name of PCMH initiative], formally and informally?
 - a. Were you involved in planning of the demonstration, including goal setting?
 - b. To what extent are you involved in implementing or monitoring the implementation of the [state-specific name of PCMH initiative], formally and informally, if at all?
 - c. To what extent are you asked and given opportunities to provide input into how to refine the state-specific name of PCMH initiative], formally and informally, if at all?
4. For the problems that you've already identified in caring for [special populations the interviewee represents], to what extent has [name of state]'s [state-specific name of PCMH initiative] and its participants addressed those issues?
 - a. How has [name of state]'s [state-specific name of PCMH initiative] and its participants tried to improve care for [special population interviewee represents]? Could you give me an example of that?
 - b. How could [the state-specific name of PCMH initiative] and its participants do an even better job serving the needs of [special population]?
5. What have been some of the **successes** achieved by the [the state-specific name of PCMH initiative] and its participants since it first began in [year that state initiative began]?
 - a. Since CMS/Medicare joined in [2011/2012]?

6. What have been some of the **challenges** encountered by [the state-specific name of PCMH initiative] and its participants since it first began in [year that state initiative began]?
 - a. Since CMS/Medicare joined in [2011/2012]?
7. From your perspective, are most [special populations the interviewee represents] aware of [name of state]'s [state-specific name of PCMH initiative]?
 - a. *[If no:]* What steps are being taken to make them more aware, if any?
 - b. *[If yes:]* How did most of them find out about [state-specific name of PCMH initiative]?

Beneficiary Experience with Care

[Note to interviewer: (1) Try to ask respondents to identify medical home features that contributed to the observed impacts, or features that could be added to the initiative to improve outcomes. (2) More specific examples of impacts to care might be discussed during the interview. For example, referrals to community resources and specialists are examples of care coordination. Other more specific examples that may be discussed in this section are: timeliness and continuity of care, coordination with specialists (physician and mental health), medication reconciliation, discussion of current and potential changes to a patient's drug regimen, provision of information such as test results to patients in a way that is easy to understand, health literacy, discussion of patient medical history, proactive care (e.g. generating lists of patients who need to come in for an office visit), and active reminders about tests, treatment, and/or appointments.]

8. Prior to Medicare (and Medicaid [in states where Medicaid is just joining the initiative]) joining [name of state initiative] in [2011/2012], what impacts has the [name of state]'s [state-specific name of PCMH initiative] had on patients who [are/have] [special populations]?
 - a. Is there evidence of improvement in:
 - i. Access to care;
 - ii. Coordination of care or care transitions,
 - iii. Increased adherence to preventive services?
 - iv. Reduced acute care utilization, like ED visits, hospitalizations, readmissions?
 - v. Patient experience/satisfaction?
 - vi. Self-management of health conditions?
 - vii. Engagement in healthy behaviors?
 - viii. Shared decision making between primary care providers and patients, their family members, and/or caregivers?

- ix. Health?
 - x. Other?
- b. To what extent do the impacts observed differ depending on whether the patients are Medicare beneficiaries, Medicaid beneficiaries, or other special populations?
 - c. To what extent do the impacts observed differ depending on demographic (e.g., race/ethnicity), language, gender, or disability status?
9. Now that Medicare (and Medicaid [in states where Medicaid is just joining the initiative]) [has / have] joined [name of state]'s [state-specific name of PCMH initiative], what new impacts do you expect to see?
- a. Do you anticipate better access to care? If so, please explain how. For example, through expanded office hours, additional practice staff, on-line access to the practice and electronic health information?
 - b. Do you anticipate more effective patient and family or caregiver participation in health care decisions? If so, please explain how. For example through more active role in care management plans, greater use of shared decision-making tools, explicit conversation about whether other family or caregivers should be involved in care and how?
 - c. Do you anticipate increased engagement in healthy behaviors (e.g., healthy diet and exercise)? If so, please explain how. For example, through motivational interviewing or brief counseling by providers, educational materials made available in appropriate languages and literacy levels, linkages to local health and wellness classes provided by local community groups?
 - d. Do you anticipate increased adherence to preventive services? For example, cancer screening, smoking cessation, influenza vaccination, or pneumonia vaccination. For example, through motivational interviewing or brief counseling by providers, educational materials made available in appropriate languages and literacy levels, linkages to local community resources?
 - e. Do you anticipate better management of their chronic health conditions (e.g., diabetes)? If so, please explain how. For example, through motivational interviewing or brief counseling by providers, educational materials made available in appropriate languages and literacy levels, better self-management skills, linkages to local community health network/teams or resources?
 - f. Do you anticipate better coordination of care, such as between primary care and specialists or physicians and hospitals? If so, please explain how. For example, through new care coordinators in practices or health plans and community health networks/teams working with practices.

- g. Do you anticipate reduced acute care utilization, like ED visits, hospitalizations, readmissions?
- h. Do you anticipate improved patient experience/satisfaction?
- i. Do you anticipate anything else? For example, any improvements in safety, via approaches like medication reconciliation?

10. What do you see as the major barriers to achieving these goals?
 - a. For beneficiaries/patients, including special or vulnerable populations?
 - b. How about from the perspective of practices or others working with them (e.g., community health teams)?
 - c. For community health networks/teams and/or other local community health resources linked to participating practices?
 - d. For payers or policymakers?

Recommendations / Conclusions

11. How could CMS or [name of state] change [state-specific name of PCMH initiative] to better serve the needs of [special population]? Why would that help?
 - a. What other recommendations do you have to improve [name of state]'s [state-specific name of PCMH initiative]?
12. If a colleague in another state was interested in advocating for a program like [name of state]'s [state-specific name of PCMH initiative], what advice would you give them?
13. What are your goals for improving the care delivered to [name of special population] in the context of the [state-specific name of the PCMH initiative] are for the next year? What are the facilitators of or barriers to their achievement?
14. Is there anything else you would like to share about [name of state]'s [state-specific name of PCMH initiative] that we did not cover today?